UNIFORM SUSPECTED INSURANCE FRAUD REPORTING FORM

State of Department of Insurance
708 West Tower / Fraud Unit
2 Martin Luther King Jr., Dr. Atlanta, GA 30334

Criminal Referral	For State Use Only
Yes ☐ No ☐	Case No. Status

Reporting Person:	Insurance Company:	NAIC#
Mailing address:	Phone number: ( ) Fax number: ( ) E-mail address:	
Date of Discovery:	Date of Referral:	
Detailed synopsis. Attach additional pages, if necessary.		
Date of Loss / Injury: Address of Loss / Injury: (City) (State) (Zip)	Dates of Service: to Description of Service:	
Claim #	Policy #	
Reserve Amount $	Amount Paid to Date $	
Loss Amount $	Settlement Amount $	
Procedure Code Classification: ☐ CPT ☐ CDT	Claim Type ☐ PC ☐ WC ☐ HC ☐ Auto ☐ Life ☐ Disability	

Suspect Information

Type:	Name (Last):	(First):	(Middle):	Date of birth:	Age:	SSN:

Street Address (include P.O. Box and apartment #'s):	Address Type: ☐ Residence ☐ Business	Tax ID No.:	Sex: M ☐ F ☐	
City:	State:	Zip:	County:	Telephone No.: ( )	Phone Type: ☐ home ☐ cell ☐ bus.
Driver's License #:	State:	VIN:	Telephone No.: ( )	Phone Type: ☐ home ☐ cell ☐ bus.
Vehicle Year:	Make:	Model:	License Plate #:	Reported Injuries:
Employer:	Address & Phone #:			Occupation:

Case Details (check all that apply)

☐ Statements (Witness / Insured / Subject)	☐ EUO / Deposition	☐ Law Enforcement / Other Agency Reports
☐ Sworn ☐ Recorded	☐ Copies of Receipts	☐ Claim History Extracts
☐ Proof of Loss	☐ Expert Reports	☐ IME Reports
☐ Continuance of Disability Forms	☐ Videos / Photos	☐ Investigative Reports
☐ Medical Records	☐ Claim Information	☐ External Database results
☐ Other	☐ Other	☐ Other

Identify Other Agency You Have Contacted Regarding This Referral

Agency: _____
Contact Person: _____
(Address) _____ (City) _____ (State) _____ (Zip) _____
Telephone (___) _____ Fax (___) _____ Case No. _____
Other Insurance Companies Involved? Yes ☐ No ☐
If you answered yes above, name of insurance company: _____
Contact Person: _____
(Address) _____ (City) _____ (State) _____ (Zip) _____
Telephone(___) _____ Fax (___) _____

SIU Investigation Completed ☐ Yes ☐ No Date Completed:

Is there any reason to believe that this incident is related to other suspected fraudulent activity? ☐ Yes ☐ No
If yes, explain:

Suspected/Fraud Types (check all that apply)

- ☐ Arson
  - ☐ home ☐ vehicle ☐ business
- ☐ Fictitious loss ☐ damages
- ☐ Fictitious theft
  - ☐ vehicle ☐ property
- ☐ Inflated inventory
- ☐ Inflated loss ☐ damages
- ☐ Inflated theft
  - ☐ vehicle ☐ property
- ☐ Double-dipping
- ☐ Exaggerated injuries
- ☐ Injuries not related to work
- ☐ Malingerers
- ☐ Misappropriated vehicle salvage
- ☐ Premium avoidance
- ☐ Prior injuries
- ☐ Slip and fall
- ☐ Staged injury / accident at work
- ☐ Staged collisions
- ☐ Paper accidents
- ☐ Other _____
- ☐ Agent fraud
- ☐ Application fraud
- ☐ Billing for services/products not provided
- ☐ Failure to disclose multiple insurance companies
- ☐ False claims
- ☐ Illegal solicitation (cappers)
- ☐ Issued fraudulent insurance policies, certificates, binders, ID cards
- ☐ Misrepresentation of services/products products
- ☐ Kickbacks/bribery
- ☐ Money laundering
- ☐ Multiple claims
- ☐ Possession/sold fraudulent insurance policies, certificates, binders, ID cards
- ☐ Questioned documents
  - ☐ altered ☐ forged ☐ falsified
  - ☐ duplicated
- ☐ Received compensation for referral to health care provider or attorney
- ☐ Ring / organized activity type
- ☐ Duplicate billing for same service
- ☐ Forged prescriptions
- ☐ Fraudulent death claims
- ☐ Over-utilization of services
- ☐ Prescription abuse / doctor shopping
- ☐ Unbundling
- ☐ Upcoding
- ☐ Misrepresented non-covered services as covered
- ☐ Changing dates of service, CPT/CDT/diagnostic codes
- ☐ Products billed are inconsistent with the products
- ☐ Using unqualified persons to perform billable services
- ☐ Other _____

Subject / Additional Party Types

CL	Claimant
IN	Insured
WT	Witness
LC	Lawyer for Claimant
LI	Lawyer for Insured
INS	Insurer
SI	Self-Insured
IY	Insurance Company Employee
IB	Agent/Broker
IS	Adjuster
IR	Appraiser
BS	Body Shop
SY	Salvage Yard Owner / Employee
TY	Tow Yard Owner / Employee
MD	Medical Doctor
DO	Doctor of Osteopathic Medicine
DEN	Dentist
PH	Pharmacist
CHI	Chiropractor
NP	Nurse Practitioner
LPN	Licensed Practical Nurse
PT	Physical Therapist
PA	Physician's Assistant
OP	Optometrist
PO	Podiatrist
RD	Radiologist
MT	Massage Therapist
AMB	Ambulance Service Employee
DME	DME Supplier
HHA	Home Health Agency
MR	Laboratory
MH	Medical Clinic/Hospital
MZ	Office Administrator
BS	Billing Services
TPA	Third Party Administrator
FP	False Provide
UP	Unlicensed Provider
MN	Other Medical Personnel
MS	Medical Specialist
	_____
DS	Dental Specialist
	_____
NS	Nurse Specialist
	_____
OT	Other
	_____

O.C.G.A. § 33-1-16. Investigation of fraudulent insurance act; collection of evidence; immunity from liability; public inspection; enforcement.

O.C.G.A. § 16-10-26. False report of a crime.

A person who willfully and knowingly gives or causes a false report of a crime to be given to any law enforcement officer or agency of this state is guilty of a misdemeanor.

Additional Parties Involved / AKA Information

Type:	Name (Last):	(First):	(Middle):	Date of birth:	Age:	SSN:

Street Address (include P.O. Box and apartment #'s):	Address Type: ☐Residence ☐ Business	Fed. TIN☐ EIN ☐ Number:	Sex: M ☐ F ☐
City: State: Zip:	County:	Telephone No.: ( )	Phone Type: ☐ home☐ cell☐ bus.
Driver's License #: State:	VIN:	Telephone No.: ( )	Phone Type: ☐ home☐ cell☐ bus.
Vehicle Year: Make: Model:	License Plate #:	Reported Injuries:	
Employer:	Address & Phone #:	Occupation:	
Involvement in referral:			

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